

## Unequal Soviet Childhoods and Post-Soviet Health Inequalities

By: [Julie V. Brown](#), Nina L. Rusinova

Brown, J.V., & Rusinova N.L., (2010) Unequal Soviet Childhoods and Post-Soviet Health Inequalities. *International Review of Modern Sociology*, 36(2): 121- 142.

Made available courtesy of Serials Publications Pvt. Ltd:

<http://www.jstor.org/stable/41421386>

**\*\*\*Reprinted with permission. No further reproduction is authorized without written permission from Serials Publications Pvt. Ltd. This version of the document is not the version of record. Figures and/or pictures may be missing from this format of the document. \*\*\***

### Abstract:

This paper analyzes contributions of the Soviet system to Post-Soviet health inequalities. Utilizing survey and interview data collected in St. Petersburg, Russia, 1992 - 2008, and focusing on the post-War generation, we analyze SES differences in early life experiences of Soviet citizens. Our results indicate the extent to which material and psychological foundations of health, health beliefs, illness experiences, and quality of medical care correlated with SES. Higher status individuals had far healthier childhoods and brought significantly more social, cultural, and health capital into the Post-Soviet transition. Under the new conditions health inequalities are greater but they follow similar patterns

**Keywords:** Health Beliefs | Socio-economic status | Russia | Medical care

### Article:

Widespread and serious health problems throughout Eastern Europe have been a focus of concern since the early 1990s. Given that these problems emerged into public consciousness as the Soviet Union was disintegrating, it is hardly surprising that the effort to account for them has focused on the social, economic, and political changes that swept through the region after the late 1980s. This health crisis, in other words, has widely been interpreted as a "Post-Soviet" phenomenon (Brainerd and Cutler, 2005; Federov and Sahn, 2005).

A goal of this paper is to argue for a broader and more systematic focus on the contributions of the Soviet system to Post-Soviet health conditions and in particular to health disparities. Despite an ideology promoting collectivism and egalitarianism, position in the Soviet social structure was a strong predictor of health. Soviet citizens brought previously accumulated "health capital" with them into the dynamic new conditions after 1991. That heritage equipped some better than others to cope with the challenges posed by the transition.

The data on which this analysis is based were collected between 1992 and 2008 in St. Petersburg, Russia. During that interval we conducted large surveys (1992, 1998, and 2007) with stratified random samples of the adult population. We also completed lengthy structured follow-up interviews with 94 middle-aged individuals from different levels of the urban social structure. Our overarching goal has been to identify and account for structured inequalities in health in the USSR and Post-Soviet Russia. Our data clearly demonstrate that health inequalities have increased since the end of the Soviet era, but they are not a new phenomenon. Significant health inequalities existed prior to the 1990s, and we argue that taking Soviet era social patterns into account is essential to understand Post-Soviet health conditions.

We focus here on the health consequences of early life experiences for people who grew up after World War II. Our interview respondents were all born during the two decades after the war. This is the cohort which is currently experiencing particularly high morbidity and mortality. We questioned them at length about their early lives to assess the extent to which health potential was linked to socioeconomic status in the Soviet system. "Health potential," refers to "all those characteristics, whether embodied physiologically or behaviorally, that people take with them [from childhood] and that, to some extent, affect their health, independent of changes in their later socio-economic environment" (Wilkinson, 1986:6). Childhood is important, because during this phase of life, health is "under development" (Graham, 2007).

All our respondents lived in St. Petersburg (formerly Leningrad) as adults; however, many grew up elsewhere. Some were reared in provincial cities; others in rural villages. We asked them about material well-being and exposure to familial conflict, since both have been demonstrated to be strong predictors of adult health (Evans & Kim, 2007; Kaplan and Salonen, 1990; Lundberg, 1993, 1997). We also queried respondents about their early illness experiences, medical care, and health-related attitudes and beliefs that they learned in their families of origin.

We used education as the primary indicator of SES. In our initial (1992) survey sample, education correlated highly with occupation ( $r = .179$ ;  $p < .004$ ) but neither education nor occupation correlated with income ( $r = -.004$ , ns;  $r = .104$ , ns, respectively). For the purposes of this analysis of childhood conditions we utilized father's education and distinguished three levels: higher education (Intelligentsia), complete secondary education (Skilled), and primary or incomplete secondary education (Unskilled).

In the initial survey we asked respondents whether they believe that their adult health problems could be attributed to difficult living conditions in childhood. More than one in four (27%) responded in the affirmative, although individuals born prior to the mid-1950s were almost four times more likely to do so than were younger people (48% vs 13%). Living conditions in the USSR were much more difficult prior to 1953, and older people are more likely to experience health problems. Thus, a large difference is hardly unexpected. More noteworthy is the consistency with which reports of "unhealthy" childhood conditions correlated with parents' socioeconomic status. Regardless of the era in which Soviet children grew up, doing so in a

household headed by a father with higher education markedly reduced the likelihood that they would be exposed to conditions known to compromise adult health.

### **Material Well-being: Early Deprivation and Health**

Significant social stratification continued to exist throughout the decades of Soviet power. Nonetheless, there has been little analysis of the relationship between structured inequalities and health, and the extant research is quantitative in nature (Andreev et al, 2009; Kislitsyna, 2009).

Our qualitative data help us to identify some of the mechanisms through which social inequalities affected health potential. While the prevailing view is that the Soviet social safety net protected the population from health-threatening deprivation, our research indicates that large holes remained, particularly in the decades following World War II. We begin by focusing on nutrition. Diet is critical to health, and food was by far the largest item (as high as 60%) in Soviet household budgets (Matthews, 1986). Malnutrition, particularly if experienced during the earliest years of life, can permanently stunt physical, psychological, and intellectual growth, and the Soviet system did not protect all children from that health risk.

Eleven percent of the adults we surveyed characterized their childhood families as living in "dire straits, sometimes even going without food." Nonetheless, even in difficult times, *Intelligentsia* families were far more successful in providing their offspring with necessary nutrition. In fact, in our interview samples no child born into an *Intelligentsia* family after World War II described any childhood experience of severe material deprivation.

Members of that post-war cohort offered us vivid descriptions of childhood experiences of feast and famine, and their life stories clearly illustrate the links between social structural position and material well-being. Life at the bottom was hard, as the experiences of Irina V. attest.<sup>1</sup> Despite the fact that her Unskilled and uneducated parents both worked in the Leningrad food industry, she remembered being "constantly hungry. We didn't have enough money. My grandmother would boil potatoes. We ate them with oil, onions and bread. There was nothing else in the house." The only "feast" Irina could recall occurred when her father worked at a beverage factory and could purchase cheap leftover lemons and oranges. During that brief interlude, she wistfully remembered, "We had enough vitamins. We even had a lot of them."

Others were worse off. Světlana N., who worked as a school dishwasher when we met her, grew up in circumstances similar to Irina. Her Unskilled father was disabled, and the large family lived in a damp basement apartment deemed unhealthy by the state. As a result, she and her three siblings spent much of their childhood in a boarding school ( *internat* ) where they were clothed and fed by the state. Asked about her childhood, she could recall only privation. Its extent is suggested by her pride in what she has achieved as an adult: the ability to provide her children with an occasional apple. As she noted with evident pleasure: "that's something I never saw in my childhood. My children have seen everything!"

These parents carried heavy loads, in many cases working multiple shifts merely to put food on the table. There was no time to study nutrition, read cookbooks, or discuss "healthy" eating habits with children. Nor could parents be at home to supervise eating regimens. Children from poor families were typically left to cook food for themselves or to reheat dishes prepared earlier by exhausted mothers. Despite low wages and back-breaking work, the mothers of several of our respondents sought out jobs in the food production and distribution industry in hopes that the direct access would make life easier. Finding, purchasing, and preparing food was a never-ending chore.

The accounts of two women who grew up in the same far northern region vividly illustrate the impact of SES on diet. Elena B., the daughter of Unskilled saw mill workers, described how hard it was for her parents to feed their family: "the quality [of our diet] was very poor. We lived in the north. There were shortages there. We never saw [fruit] in the winter.... On holidays, of course, my mother would try to buy something delicious," but celebrations were rare and the fare exceedingly modest.

By contrast, the parents of Galina A. were highly educated professionals. She was acutely aware of the advantages that had afforded her: "the quality of our diet was wonderful. Even in that era [late 1950s - early 1960s] we had [expensive] fish, as well as tangerines, oranges, apples. Things were hard there in the north but it never affected us we had everything instantly. [My parents] paid close attention to our diet.... it was family tradition that there was always only fresh food for dinner."

Insufficient caloric intake and vitamin deficiencies both have direct implications for short and long term health, and our survey data indicate statistically significant correlations between adult health and early material deprivation.<sup>2</sup> Interviews also suggest more subtle but significant psychological and behavioral effects. Severe material deprivation in early life was frequently associated with potentially unhealthy adult attitudes toward consumption in general and toward diet in particular. A high priority for many who had experienced great poverty was to ensure that their own offspring lived better. Parents were very willing to sacrifice their own health to achieve that goal, even if it meant, as one woman put it, "to eat only porridge for a while" in order to purchase nice clothing for her teenaged son.

Painful experiences of childhood poverty often culminated in a reluctance to deprive oneself in adulthood-even in the interest of health. Typical is the attitude of Andrei V, who adamantly insisted, "I try not to restrict myself in any way." The son of an Unskilled metal worker, Andrei grew up in a crowded Leningrad communal apartment with few possessions. The best he could say about the family's diet was, "We didn't starve." The quality was poor, because "we lived in poverty... even worse than most others."

Andrei's unwillingness as an adult to regulate his diet (or stop smoking) are noteworthy, given that he had already survived a heart attack and suffered from a painful stomach ulcer. Still, he

failed to see the point of self-sacrifice. His conception of a "healthy" diet was one comprised of foods he liked. The belief that "people should eat what they enjoy" was widespread among men in his social stratum.

The experience of childhood poverty had other long-lasting effects on adult lifestyles. Severe material deprivation early in life was associated with a generalized passivity and extremely low expectations. As one woman put it, "all [her Unskilled mama] wanted was to hang on to life long enough for me to grow up." Success in life, in other words, merely meant surviving into middle-age.

People born to parents with a higher education described very different dietary experiences. Hunger was unknown. While not everyone recalled opulent meals of "crab and caviar/" almost every person we interviewed remembered that, "We had everything we needed... vitamins, fruit, vegetables. [Parents] watched out for that. We had to eat a big breakfast before school, and we always had to come home to eat after school." Adults actively monitored the eating habits of offspring: "it was always the rule in our family that there was a dietary regimen. My father could come home for dinner. He supervised the regimen."

The importance of eating well was implanted early and the consequences have been enduring. Nelli P., daughter of a school administrator and a teacher herself, summed it up clearly: "We always ate very well. The food was prepared properly, according to the cookbook. It was beautiful food, very aesthetically pleasing. I got so accustomed to this that we still eat the same way.... With mama everything was very precise: breakfast, dinner, supper, and all at the proper time. I attribute both my health and the fact that my mama is still alive and very healthy to the fact that we always ate well."

The ability of Intelligentsia families to sustain these dietary patterns was dependent upon the availability of resources that were beyond the reach of most other families. One critical factor was their mastery of the informal economy. Because the Soviet command economy was prone to shortages, acquiring deficit consumer goods (from food and clothing to refrigerators and automobiles) usually depended at least as much upon the "ability to obtain" (*dostat'*) as upon the "ability to pay" (*platit'*). While the latter was largely determined by income, the former reflected access to and mastery of informal economic mechanisms, including personal "connections" (*sviazi or blat*). (Ledeneva, 1998) While their incomes were not significantly higher than those of Skilled workers, Intelligentsia families tended to have more and better possessions, especially of the kind which were historically difficult to acquire. They also spent a smaller proportion of their incomes on food than other people. Nonetheless, they typically ate better.

So far we have focused on two strata at opposite ends of the social hierarchy; however, many people grew up in households of a third intermediate type. In these families one or (more commonly) both parents had complete secondary educations and were employed as Skilled blue collar or low level white collar workers.

On the whole these families had a higher standard of living than the Unskilled, but their levels of well-being were lower than Intelligentsia families. Wage levels for these kinds of workers enabled them to meet the basic needs of their families, but households tended to be larger. Thus, there were more mouths to feed. Incomes were typically high enough to purchase basic food and clothing but little else. Our respondents did not experience recurring hunger, but they remembered very simple diets: "I'd say that our diet was normal, but, of course, without anything special." "Grandma raised us on porridge. Every morning there was some kind of porridge. On the whole we ate very simple food, without delicacies."

Although their incomes were higher than those of the Unskilled, feeding children remained the central task facing these parents, and they utilized a variety of methods to accomplish it. When possible they produced their own food. Vera A., who grew up in a village, remembered that, "Everything was our own-livestock, garden. In summer we preserved mushrooms and berries.... we had meat and a lot of milk." Some Skilled worker families had access through their workplace to a small plot of land which they used to grow vegetables to see them through the winter. (Intelligentsia families also had these plots but typically used them largely for recreation.)

Most Skilled parents worked long hours (often at more than one job), which enabled them to provide their families "a minimal but adequate" level of material well being. While far from affluent, children's basic physical needs were met. Still, most of our respondents from this social stratum were socialized to be satisfied with a relatively low standard of living. This approach to life has limited their success in adapting to the social and economic changes ushered in by the Post-Soviet transition and put them at increased risk of morbidity and mortality in middle age.

### **Emotional Malnutrition: Intra-familial Conflict and Health**

The disproportionate number of absentee and /or overworked parents in the lower social strata points to another significant risk to health potential that was unequally distributed among Soviet children: "emotional malnutrition." Some researchers argue that exposure to intra-familial discord has more dire consequences for adult health than material deprivation (Felitti et al, 1998; Lundberg, 1993). Thus, we queried both survey and interview respondents about the "family atmosphere" in which they grew up.

Our data confirm that happy families were easier to sustain when material resources were plentiful. Overall, more than half (55%) of our survey respondents described the atmosphere in their childhood homes as "good." Among those who grew up in the most deprived households only a third (38%) did so. Those individuals were also more than twice as likely as others (26% vs 10.4%) to describe the atmosphere as "bad." Those findings were confirmed in the interviews. When we asked people to reflect on their early lives, those who grew up in poor families were the most likely to describe their childhood as "unhappy," citing both physically and emotionally unavailable parents as well as overt conflict. While our respondents understood and to a striking

degree sympathized with the exhausting lives their parents endured, that did little to make up for the psychological deprivation. "I didn't get any attention," remembered Larissa V, "My parents didn't have any time. They worked like horses." The only affection Larissa could recall was provided by a grandmother, who cared for her when she was very young. Unfortunately, her grandmother died early from tuberculosis, although not before passing the disease on to Larissa.

Parenting in these families focused overwhelmingly on meeting the material rather than the psychological needs of children. Our respondents attributed this in part to the character traits and upbringing of their parents. "My father was strong, an authoritative, even cruel person," observed Alexander V., son of a construction worker. "He had never been spoiled and for that reason he was very strict with his children and his wife." "My mother had a very strong character," recalled Liudmilla F. "I never had enough affection. I wanted more tenderness, for her to say a few extra words to me, but that rarely happened."

Intra-familial conflict was also common. Perceived infidelity could spark arguments. Evgenia A.'s father suspected her mother of infidelity. They ultimately divorced but prior to the separation "there were conflicts.... He was very jealous, of course. Mama was ten years younger. I never knew if there was any basis for [his suspicions]. I never saw it. Maybe he just wasn't a very nice man."

Adults also fought over scarce resources. Vladimir A., recalled a particularly nasty fight after his father discovered that his mother had bought him a musical instrument, "my most prized possession." Mikhail V. described repeated parental arguments in which his overworked mother condemned his father's "selfishness," for leaving home on factory-subsidized sanatorium visits.

There was a particularly acute housing shortage in Leningrad in the post-war era. Much of the housing stock was damaged during a prolonged siege of the city, and when the hostilities ended, migrants swarmed into the northern capital. Most of the post-war population lived in communal apartments, sharing kitchen and bathroom facilities with other families. The chronic housing problems that plagued Soviet Society have been well chronicled, but there has been very little consideration of the direct and indirect health consequences of the poisonous atmosphere in which many children grew up because of them (Boym, 1994; Kislitsyna, 2009).

Crowded living conditions exacerbated family conflicts and could create a destructive self-perpetuating cycle: family members who engaged in extended fights over space were less likely to support each other in dealing with other kinds of crises, such as the extended illness of a relative. Rifts sometimes continued long after housing problems were solved, and the stress could take a huge toll on children.

Due to the acute housing shortage, it was not uncommon for divorced couples to have to continue to share living space. Thus, the legal end of a troubled marriage did little or nothing to protect children from parental conflicts. Marina V. described the atmosphere in her Leningrad

home as "...nerve wracking. The situation was awful before and after the divorce. We all had to keep living together in one room for three years after they divorced."

Despite the on-going housing deficit, fewer than half (44%) of our Intelligentsia interview respondents had lived in communal housing as children. By the early 1970s all of their families had managed to acquire separate apartments, and most did so much earlier. The factors that explain their success in the "housing market" also offer insight into the reasons why lower SES families tended to stay stuck in crowded, unhealthy, communal housing: material resources, social and cultural capital, and stable, accessible, and supportive families were all unequally distributed among urban Soviet citizens.

By far the most persistent and far-reaching catalyst for intra- familial conflict was alcohol abuse. Overall, nearly one in four (24.2%) of the adults we surveyed acknowledged growing up in a household that included an alcoholic, but that experience was far more common in non-Intelligentsia households. Only six percent of families in which both parents had a higher education included an alcoholic member. Intelligentsia families were smaller and, given their success in negotiating the housing market, were less like to share physical space with relatives who were not part of the nuclear family. This reduced the likelihood that the household would include an alcoholic uncle or brother, a situation frequently described by people from lower social strata.

Regardless of social status, the household alcoholic was typically the father (80%). Since fathers were also usually the primary breadwinners, alcohol abuse could adversely affect both the financial and the emotional well-being of a family.

We focus here on the psychological toll, which our data indicate has been significant and enduring. More than three out of four (76%) of the people who grew up with an alcoholic family member insisted that they were adversely affected by the experience. One in three (33%) indicated that life at home was so unbearable that they stayed away as much as possible. Memories of the strife are quite graphic. Sergei A., the son of a railroad worker and a clerical worker recalled that his father was frequently on the road. But when he was home "my mother and father were constantly brawling. My father drank and, I realize in hindsight, also ran around with other women. They argued all the time. They were constantly separating and getting back together again. My childhood was difficult-nobody to console or comfort me.... I cried all the time. It was hard. It had a big impact on me." Like several other men in our study, Sergei told us that he tried to defend his mother from physical attack, "As a result I started stuttering. I still stutter. Naturally,... as a young adolescent, I tried to protect my mother." Alcoholic and abusive fathers also used physical force against their children. Fedor V., spent much of his childhood with grandparents who tried to protect him from being beaten by his alcoholic father. "For all intents and purposes they raised me," he remembered, "but I preferred to be with my mother."



The "leaving and returning" pattern described by Sergei was especially common in poor families. Thus, it was mostly lower SES wives and children who continued to endure emotional and physical abuse. Sergei attributed his father's drinking problems to the lingering effects of wartime trauma, but knowing the origins of the problem did little to lessen the impact: "There were conflicts. We didn't escape those. Mostly they were due to his drinking. I got really upset. So did my mother. Several times we left and went to my grandmother's, but then we came back. Maybe we should have left and not returned but we had real money problems. That was why my mother could never decide to leave permanently."

As Tolstoy (2004) pointed out, unhappy families are not all alike. Nonetheless, there clearly are structural forces that make achieving a happy (and "healthy") family environment more difficult. In late Soviet society, alcohol abuse was prominent among these. Even in Intelligentsia families the presence of an alcoholic relative caused turmoil; however, households with greater capital (social, cultural, and financial) were better positioned to cope with the problem.

Paradoxically, in some of the least educated and very poorest households at the bottom of the urban social structure the emotional environment described by our respondents was positive and supportive. As we looked for an explanation for this pattern, it became apparent that these were households in which there were no adult males, i.e., they were homes headed by single mothers. More than 40% of our Unskilled respondents lost their fathers before the age of 18 due to death or abandonment; another 10% never knew them. Without a male breadwinner, these households struggled for elemental survival. Nonetheless, absent the emotional turmoil associated with alcohol abuse and other parental discord, our respondents remembered calm and happy childhoods. Mothers worked tirelessly to provide for their offspring, but what our respondents described most vividly was not the privation but maternal efforts to create a good home environment. The unconditional love and warmth they experienced early in life helped them through very difficult periods, and the memories clearly continue to nourish them in adulthood: "my mama was so good, so very kind/" remembered Olga I, a bus park operator. "We were friends... she was such a good hostess. She loved all of my friends." Elena M., a janitor with multiple adult health problems, wistfully recalled that her illiterate mother "did everything. She cooked, cleaned, did the laundry. I don't know how to do anything. Mama spoiled me, that's for sure."

Olga's father died when she was a toddler, and Elena never knew her father. The mothers of both women died when their daughters were adolescents. Despite the desperate poverty in those fatherless households, each woman remembered childhood as the best period of her life and acknowledged her mother's sacrifices: "I didn't understand about life," Elena mused, "a child is a child, what can you say? I don't know how she did it all."

Among our respondents were also individuals who endured extreme psychological and material deprivation. Several spent their childhoods in state institutions because of their parents' social situations. For these children there was no emotional support to compensate for the material

hardships. What they recalled was severe psychological deprivation, and remembering childhood was clearly painful: life was "very difficult." Even on the rare occasions when they could be home, parents had no time for them. These individuals performed poorly in school, had trouble forming relationships with other children, and terminated their educations as early as the law allowed.

Thus, although many of the individuals who grew up in Unskilled households experienced health-threatening material deprivation, there was great variation in their exposure to social-psychological trauma. Some suffered terribly; others grew up in a loving caring atmosphere. Nonetheless, uneducated parents were not equipped to assist children with school work and the combination of difficult living conditions and material need prompted most to abandon formal education and move into the labor force far earlier than young people higher in the social structure. Everyone we interviewed from this stratum was already engaged in full time work by the age of fifteen. They also married and started their own families very early, adding, at least for the women, yet another long term risk to health (Graham, 2007). While still adolescents, these men and women were already consumed by the endless task of putting food on the tables of their own rapidly growing families. Severe deprivation in early life, in combination with limited educations and job skills, poorly equipped them to adapt to the rapid change in the 1990s. Their Soviet era experiences put them at increased long-term risk of serious illness and premature death.

Among the many childhoods chronicled for us, the only unqualifiedly glowing reports of "healthy" family lives came from offspring of the Intelligentsia. A prime example is German G., a medical scientist who had followed in his physician father's footsteps. German had this to say of his early life: "my parents were relatively well off.... Good diet, a stable family with caring adults to look after you. Those are the elements of a healthy childhood.... It was a happy atmosphere."

That intra-familial conflict and exposure to alcohol abuse early in life have long-term consequences for health is evidenced in statistically significant patterns in our survey data. We measured health using the SF-36, a widely utilized tool that assesses eight different dimensions of health (Bowling, 2001). Controlling for age, we found that the more negatively respondents assessed the atmosphere in the homes in which they grew up and the greater the perceived negative impact of growing up with an alcohol abuser, the worse was their health at the beginning of the 21st century.<sup>3</sup>

### **Attitudes toward Sickness and Health**

As children we are exposed to a set of attitudes toward health as well as strategies for dealing with illness. While research on the links between attitudes and beliefs learned in childhood and adult health outcomes is inconsistent (Blaxter, 1997; Siegal & Aboud, 2005) our findings suggest

that in this urban Russian population differences in early socialization were significant and may well be one of the factors responsible for increasing Post-Soviet health disparities.

We asked our respondents to explain what it means to be "healthy." The answers we received varied significantly across the social hierarchy. To people who grew up in *Intelligentsia* families good health entails physical and emotional well-being, the ability and desire to be active, harmony and balance in one's life, and the ability to adapt to new situations. It means the absence of all but the most minor of ailments and the capacity to recover easily from isolated illness episodes. These high standards for health, learned in childhood, are reflected in their medical help-seeking behavior as adults: careful monitoring of personal states, interest in learning about health and illness, and a readiness to seek out expert medical help promptly and aggressively (Rusinova and Brown, 2003).

Most people who grew up in lower status households defined health far more narrowly and in terms of functional capacity. Our Skilled respondents described numerous serious health problems (including heart disease, cancer, hypertension, tuberculosis). Nonetheless, they assessed their own personal health first and foremost in terms of their ability "to be able to work without taking any sick leave" or "to have energy to do things with my son." Folks in this social stratum consider themselves healthy if the symptoms they experience do not interfere with their role responsibilities. That attitude is typified by Fedor F., a semi-employed factory worker, who told us that he considers himself healthy, because he can live a "normal" life, despite the fact that he has officially diagnosed illnesses. As he put it, "I've got lots of prescriptions for medications lying around the house which I have no intention of buying." Those unfilled prescriptions suggest that his physicians are less sanguine about the state of his health.

This view of health and illness is not conducive to early proactive intervention, and it is reinforced by a stoicism regarding pain and suffering that lower status individuals in particular were raised to respect and emulate. This emerged clearly from our respondents' accounts of both their own illnesses and the illnesses of close relatives, who were consistently praised for enduring serious medical problems without complaining.

Iurii A., a truck driver, described at length his mother's unsuccessful struggle with ovarian cancer. Despite terrible pain, he remembered that she had always focused on the well-being of others: "She didn't want to wear out the people around her. She even apologized to me, 'forgive me for burdening you with all these [hospital] visits.'" Iurii described his mother as a woman of "the old school," [*staroi zakalki*], employing an expression that implicitly equates strength of character with physical hardening. Lydia V., a former hospital worker, had similar praise for her mother who endured a lengthy hospital stay without burdening her family: "She's great [*molodets*]. She never asked anybody for a single thing."

While it is tempting to look for the origins of these attitudes in Soviet era ideologies of collectivism and self-sacrifice, we argue that their roots are much deeper. Our respondents

discussed these norms almost exclusively in terms of familial rather than broader societal obligations. They were learned in childhood, and they are linked both conceptually and linguistically with notions of "hardening" (*zakalivanie*) that trace back many centuries (Ivanchenko, 1985; Ransel, 1991).

The idea that physical "hardening" can stave off illness is widespread; however, it is interpreted differently across the social structure. For Intelligentsia parents it suggests very specific strategies for health promotion, such as encouraging children to run around barefoot, dousing them with cold water and leaving their baby carriages outside in winter. For people lower in the social structure the dominant view is that hard physical work and economic hardship "naturally" harden people. The behavioral implications are clear: If you are able to work, and you believe that your demanding life "naturally" protects you from illness, what reason is there to engage in "artificial" health promoting activities or even to question whether you are healthy?

Health-related attitudes inculcated in childhood continue to influence adult lifestyles. The fact that people who grew up with Skilled parents devote little overt attention to health represents a continuation of family tradition. Their parents "did nothing" to keep them healthy, they insisted, because, "We were outside all the time. We were always out in the fresh air. And we were given physical work." The only type of health-promoting activity any of these individuals described was physical exercise intended to build muscles and increase physical endurance - activities fully consistent with their understanding of health as the ability to engage in physical work.

Equating health with physical strength and the ability to work, these individuals believe that their life styles are inherently strengthening, despite the fact that many of them smoke and drink heavily. Smoking is very widespread among men in this urban population; however, rates of smoking vary by SES. Nearly seventy percent (69.6%) of men raised by Skilled fathers are smokers. Among sons of the Intelligentsia the comparable figure is 56.7%. The latter are also far more likely to report that they used to smoke but gave up the habit more than two years ago (19.9% vs 13.5%).<sup>4</sup>

Given Russian cultural patterns and the significance of alcohol consumption for health, we asked a variety of questions in surveys and interviews about alcohol consumption (e.g. frequency of consumption, beverage preference, usual drinking partners, typical purchase site, average number of grams of alcohol consumed per drinking session). Not surprisingly, consumption patterns vary significantly across the SES hierarchy, but, regardless of social status, men drink more heavily than women. The preferred beverage of individuals from non-intelligentsia backgrounds is vodka (70.1%), while people from more educated families drink a wider variety of beverages, most of which have a lower alcohol content (e.g. beer, wine). Frequency of drinking correlates inversely with father's educational level: the less educated the father; the more often both men and women consume alcoholic beverages ( $r = -.058$ ;  $p < 0.05$ ).

The reports of our interview respondents reveal clearly how different drinking patterns are across the social landscape. "I prefer wine," observed Efim B., a small businessman and son of a teacher, "but it's been a long time since I got drunk. Occasionally I might drink half a bottle of wine. It depends on the situation." Anatoly I., on the other hand, a skilled worker like his father, told us that, he drinks a couple of times a week at work or with friends: "To tell the truth," he noted, "I usually drink a bottle of vodka, but naturally always with good appetizers." Half of the men we interviewed who had grown up with Skilled fathers acknowledged that they have abused alcohol at some point in their lives: "Sometimes I go on a four-day binge. But then I stop drinking."

The understanding of health as functional capacity was pervasive among individuals whose parents had secondary educations. Neither the presence of diagnosed illnesses or unpleasant symptoms was sufficient for these individuals to regard themselves as unhealthy. The implications are suggested by the observations of Andrei V, a heart attack survivor. "I don't get sick often," he noted. "But when I do it's right away with something serious like a heart attack or an ulcer." In other words, as he saw it, he (and his cardiovascular system) had been perfectly healthy until the moment when he was struck down by a myocardial infarction.

Although this overall approach toward health was common across non-Intelligentsia groups, the attitudes of the Unskilled, at the very bottom of the social structure, were distinctive in other ways as well. They were clearly the most fatalistic about health. These were the only people who insisted that personal health was so far beyond their control that it was useless even to think about trying to change anything. "There are people who have survived so much and they just keep going. And then there are 'weaklings!'" "It's how a person was born." "Whatever you do, it's impossible to change anything."

Unlike people higher in the social structure, the Unskilled see no point in learning about health. Indeed, the whole notion of "health promotion" was foreign to them. Rather, their attitude was, "I was never interested in [health] and in general I try not even to think about it." When conditions dictated some kind of action, as for instance when a child contracted a serious ailment, they turned over all responsibility to medical experts, "I don't know anything. I trust doctors." Lacking confidence in their ability to evaluate health conditions, these individuals admitted to being fearful of new things. As Elena M., the janitor we met previously, put it, "I'm scared. I need to talk it over with somebody. I might make things even worse."

A recurring theme in the accounts of people from Unskilled backgrounds was that it is better not to acquire information about health. Irina V, a house painter, insisted, "I once read [the popular journal] *Health (Zdorov'e)* and immediately got sick. I decided that I don't need that. I need calm." Too much knowledge, in other words, can make you sick. Indeed, merely thinking about one's health might damage it: "The more you think about your physical weaknesses, the worse things will get!"

Health concepts and health-related behaviors both vary significantly across the social structure, and the approaches adopted by most adults are clearly linked with expectations learned during their Soviet era childhoods. The only exception to this pattern in our data was among people who had been upwardly mobile into the *Intelligentsia*, i.e., raised by Skilled or Unskilled parents but managing themselves to complete a higher education. In this stratum adult attitudes and behaviors differed significantly from those in birth families. Our respondents described a different dilemma: how to manage inter-generational conflicts generated by different understandings. An episode recounted by Nina V. is typical. She and her family were visiting relatives in a distant village when her young son fell ill. Nina wanted to seek immediate medical assistance, but she encountered significant resistance: "They said to me, 'what are you so worried about?'... I insisted that we should call an ambulance and they responded, 'What's the matter with you.... it's shameful to call an ambulance...'"

### **Childhood Illness Experiences**

We asked our interview respondents to describe illnesses they had experienced as children and to discuss the medical treatments they received both at home and from the formal medical care system. Literature on Post-Soviet health conditions has generally taken for granted that all Soviet children received adequate medical care. After all, the USSR created the first national health care system, and it guaranteed free care to all citizens.

Prophylactic care was a hallmark of the system. All of our respondents remembered regular school check-ups, although some people insisted that the examinations were little more than superficial screenings for problems with vision, hearing, teeth, etc. There was, however, great variability in the medical care people described. The quality of Soviet medical institutions (and physicians) was inconsistent. Accessing good care depended in part on luck but more reliably upon knowledge and "connections," both of which were far more accessible to people highest in the social structure (Brown and Rusinova, 1997).

While the routine childhood ailments catalogued for us in interviews were fairly evenly distributed across the social structure, children from poor families tended to describe the most serious health problems (Haas, 2006; Palloni, 2009). One in six (16%) indicated that weak health had prevented them from attaining a higher level of education or a better job: "I remember now how my medical record said, 'not fit [*ne godno*],' 'not fit;' I couldn't even get a job as a janitor."

It probably never occurred to the Unskilled mother whose child was deemed "not fit" to question that classification. Knowledgeable parents, however, aggressively pursued the best options for their children, even when doing so involved challenging medical authorities. This is illustrated by the approach of the lawyer mother of another of our respondents: "When I was a year and a half old, I contracted a rare illness. The doctors gave up on me, but my mama had a higher education. She went to the library and found out about the disease. She diagnosed me. [The doctors] told her 'you're still young. Just have another child'.... But she read about possible

treatments and insisted on a plasma transfusion. They did it, but then the Head Doctor took all the credit.”

Medical care may have been free to all, but well-informed and well-connected consumers were able to extract far more from the system than those who were less educated and more deferential. This could mean the difference between good health and a life of chronic illness and disability or even, as in the case just chronicled, between life and death.

Reporting about health histories is notoriously inaccurate, especially when long-term memories are involved. We relied upon individual recall rather than medical records, and our interview sample is too small for any broad generalizations about epidemiological patterns. Nonetheless, several intriguing and potentially significant patterns emerged from our interviews. We introduce one of them here because it suggests a direction for future research. Among the individuals whose post-war childhood health histories we scrutinized were a surprising number of survivors of systemic streptococcus infections (rheumatic fever and /or nephritis): at least 14% or approximately one in seven of these randomly selected individuals who grew up in different parts of the post-war USSR.<sup>5</sup> All but two grew up in relatively poor, Skilled or Unskilled households. The two exceptions lived in troubled families headed by alcoholic (albeit it highly educated) fathers and Unskilled mothers.

Most streptococcal infections can be successfully treated by antibiotics and the potentially life-threatening sequelae are usually avoidable if treatment begins promptly. There are many possible explanations for the pattern we observed: sporadic availability of relatively new antibiotics, the presence of a particularly virulent strain of strep, poor diagnostic procedures, even a mere chance occurrence in a small sample. Nonetheless, the finding is so striking and follows so logically from the other patterns analyzed in this paper that we feel compelled to address it. If privileged families had the resources (knowledge, time, connections) to ensure that their children were closely monitored and provided with the best medical care available, the experience of lower status families was quite different. Material and psychological deprivation leave children more vulnerable to illness, and overworked, absent parents are almost certainly less likely to notice early symptoms. Attitudes promoting stoicism in the face of illness and reluctance to seek medical help for "trivial" medical problems could easily discourage children from complaining and parents from responding quickly when they did. The net effect was to put these children at elevated risk of disability and death for life.

## **Conclusion**

On those rare occasions when the quest to understand Post-Soviet health conditions has led researchers back into the Soviet past, most have focused their critical lenses narrowly: on individual passivity and other "unhealthy" behaviors ostensibly fostered by the political regime and by the medical system (Andreev et al, 2009; Cockerham, 1999; Field, 2000). Without denying the relevance of these factors, we contend that the explanation is far more complex.

Depending on their position in the social hierarchy Soviet citizens lived very differently. Some lifestyles were health-promoting; others entailed significant risks to short and long-term health.

For the Post-war generation that has experienced such high mortality in recent years, health potential laid down early in life was powerfully linked to socioeconomic status: the quality of nutrition, living conditions, family atmosphere, social support, and medical care was a function of SES, and at the bottom deprivation could be severe. Adult health risk increases with cumulative exposure to stressors in early life, and our data clearly indicate the extent to which exposure levels were inversely related to SES (Chartier et al. 2010; Evans and Kim, 2007; Haas, 1998).

Health-related attitudes and behaviors also varied across the social hierarchy. People with higher educations were far from "passive" when it came to health, and upon close examination, it turns out that what some analysts have taken for passivity is in large part the external manifestation of values and beliefs (e.g. stoicism, physical hardening) whose origins lie in the distant pre-Soviet past. Uncompromising fatalism about life (and health) in our sample was confined to Unskilled people at the very bottom of the social structure.

As Blane (2006: 55) observed, "Individual biological development takes place within a social context which structures life chances so that advantages and disadvantages tend to cluster cross-sectionally and accumulate longitudinally." That has certainly been the experience of our respondents. The demise of the Soviet system created challenges for everyone but those from the lower ranks of the Soviet social hierarchy faced the greatest hurdles. The "chain of disadvantage," in other words, acquired new links after 1991 (Blane, 2006: 59). The already weak Soviet safety net nearly collapsed, inflation skyrocketed, and for the first time in seventy years there was widespread unemployment. In the short run those dramatic changes increased health risks for much of the population. Severe material deprivation, greatly reduced by the 1980s, reemerged in the early 1990s, affecting not only those who had been deprived as children but others as well.

For people who had lived well in the Soviet system but struggled to find a place in the new environment, the experience was one of acute relative deprivation. Over time, however, health inequalities have not only persisted but increased. People with higher levels of social and cultural capital have weathered the transition far more easily. Mortality levels for the Intelligentsia have actually decreased, while those for people lower in the social structure have increased (Murphy et al, 2006; Shkolnikov et al, 1998).

Every adult entered this topsy turvy era with a health foundation laid down during the Soviet period. That "health capital" could be poorly spent in the early Post-Soviet era, but few of those with little accumulation in 1991 are better off now. Post-Soviet health disparities represent continuity with rather than a break from the Soviet past. On the one hand, this is rather remarkable given the truly radical changes ushered in by the demise of the Soviet system. For a



brief time in the 1990s it did seem that linkages between education, income, morbidity, and mortality might have changed dramatically. Within only a few short years; however, older social patterns re-emerged. Thus, on the other hand, the Post-Soviet transition offers yet more evidence of the stubborn and enduring nature of SES-linked health inequalities.

## Notes

1. All of the names are pseudonyms and to further ensure confidentiality, we have made minor changes to individual biographies.
2. The correlation between "general health" and material well-being in youth was significant at the 0.05 level ( $r = .047$ ); the significance level for the correlation with "mental health" was even higher:  $p < 0.042$  ( $r = .169$ ).
3. There were significant correlations for women between family atmosphere and both "social functioning" ( $r = -.066$ ;  $p < 0.01$ ) and "role-emotional health" ( $r = -.066$ ;  $p < 0.05$ ). For men, correlations were significant for social functioning ( $r = -.131$ ;  $p < 0.01$ ). Living with an alcohol abuser correlated for men with "social functioning" ( $r = -.180$ ;  $p < 0.005$ ), "vitality" ( $r = -.300$ ;  $p < 0.01$ ), "role functioning" ( $r = -.179$ ;  $p < 0.005$ ), "physical functioning" ( $r = -.233$ ;  $p < 0.01$ ) and "role emotional health" ( $r = -.152$ ;  $p < 0.005$ ). For women the only statistically significant correlation for living with an alcohol abuser was with "role emotional health" ( $r = -.164$ ;  $p < 0.05$ ).
4. Rates of smoking are far lower for women but SES differences are even more significant for women ( $p < 0.001$ ) than for men ( $p < 0.047$ ). Among daughters of intelligentsia parents, 26.2% are regular smokers. More than a third (37.3%) of women who grew up in non-intelligentsia households smoke regularly.
5. There were several other people whom we suspected had suffered similar illnesses; however, their memories were insufficiently specific for us to be confident of a diagnosis.

## References

- Andreev, Evgueni et al. (2009). Concentration of Working- Age Male Mortality Among Manual Workers in Urban Latvia and Russia, 1970-1989. *European Societies*, 11 (1): 161-185.
- Blane, David (2006). The Life Course, the Social Gradient, and Health. In Marmot and Wilkinson (Eds.) *Social Determinants of Health*, 2nd Edition, (pp. 54-77). Oxford: Oxford University Press.
- Blaxter, Mildred (1997). Whose Fault is it? People's Own Conceptions of the Reasons for Health Inequalities. *Social Science and Medicine*, 44 (6): 747-756.
- Bowling, Ann (2001). *Measuring Disease: a Review of Disease-specific Quality of Life Measurement Scales*. Philadelphia: Open University Press.

Boym, Světlana (1994). *Common Places: Mythologies of Everyday Life in Russia*, Cambridge, MA: Harvard University Press.

Brainerd, Elizabeth and David M. Cutler (2005). Autopsy on an Empire: Understanding Mortality in Russia and the Former Soviet Union. *The Journal of Economic Perspectives* , 19 (1): 107-130.

Brown, Julie V. and Nina L. Rusinova (1997). Russian Medical Care in the 1990s: a User's Perspective. *Social Science and Medicine* 45 (8): 1265-1276.

Chartier, Mariette J., et al. (2010). Separate and Cumulative Effects of Adverse Childhood Experiences in Predicting Adult Health and Health Care Utilization. *Child Abuse & Neglect*, 34 (6): 454-464.

Cockerham, William C. (1999). *Health and Social Change in Russia and Eastern Europe* New York: Routledge.

Evans, Gary W. and Pilyoung Kim (2007). Childhood Poverty and Health: Cumulative Risk Exposure and Stress Dysregulation. *Psychological Science*, 18 (11): 953-957.

Federo v, Leonid and David E. Sahn (2005). Socioeconomic Determinants of Children's Health in Russia: A Longitudinal Study. *Economic Development and Cultural Change*, 53 (2): 479-500.

Felitti, V. J. R. F. et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults - impact on children. *American Journal of Preventive Medicine*, 14 (4): 245-259.

Field, Mark G. (2000). The Health and Demographic Crisis in Post-Soviet Russia: A Two Phase Development," in Field and Twigg, (Eds). *Russia's Torn Safety Nets: Health and Social Welfare During the Transition*, (pp. 11-42). New York: St. Martin's Press.

Graham, Hilary (2007). *Unequal Lives: Health and Socio-economic Inequalities*. New York: Open University Press.

Haas, Steven A. (2006). Health Selection and the Process of Social Stratification: The Effect of Childhood Health on Socioeconomic Attainment. *Journal of Health and Social Behavior* , 47 (3):339-354.

Ivanchenko, V. A. (1985). *Tainy Russkogo Zakalâ*. Moscow: Molodaya Gvardiia.

Kaplan, G. A. and J. T. Salonen (1990). Socioeconomic Conditions in Childhood and Ischaemic Heart Disease during Middle Age. *British Medical Journal* , 301 (6761): 1121-3.

Kislitsyna, O. A. (2009). The Socioeconomic Determinants of Russians' Health. *Sociological Research* , 48 (3): 43-60.

Ledeneva, Alena (1998). *Russia's Economy of Favours: Blat, Networking and Informal Exchange*. New York: Cambridge University Press.

Lundberg, Olle. (1997). Childhood Conditions, Sense of Coherence, Social Class and Adult Health: Exploring their Theoretical and Empirical Relations. *Social Science and Medicine* , 44 (6):821-831.

Lundberg, Olle (1993). The Impact of Childhood Living Conditions on Illness and Mortality in Adulthood. *Social Science and Medicine*, 36 (8):1047-1052.

Matthews, Mervyn (1986). *Poverty in the Soviet Union: The life-Styles of the Underprivileged in Recent Years*. Cambridge, UK: Cambridge University Press.

Murphy, Michael et al. (2006). The Widening Gap in Mortality by Educational level in the Russian Federation, 1980-2001. *American Journal of Public Health* , 96 (7): 1293-1299.

Palloni, Alberto et al. (2009). Early Childhood Health, Reproduction of Economic Inequalities and the Persistence of Health and Mortality Differentials. *Social Science & Medicine* , 68 (9): 1574-1582.

Ransel, David L. (1991). Infant-Care Cultures in the Russian Empire. In Clements, et al. (Eds.), *Russia's Women: Accommodation, Resistance, Transformation*, (pp. 113-132). Berkeley: University of California Press.

Rusinova, Nina L. and Julie V. Brown (2003). Social Inequality and Strategies for Getting Medical Care in Post-Soviet Russia. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness, and Medicine* 7 (1): 51-71.

Siegal, Michael and Frances Aboud (2005). Characterizing the Scope of Socialization and its Impact on Health. *Social Science and Medicine*, 61 (11): 2269-2271.

Shkolnikov, Vladimir et al. (1998). Educational Level and Adult mortality in Russia: An Analysis of Routine Data 199 to 1994. *Social Science and Medicine* , 47 (3): 357-369.

Tolstoy, Leo (2004). *Anna Karenina.*, trans. Richard Pevear and Larissa Volokhonsky. New York: Penguin Classics.

Wilkinson, Richard G. (Ed.) (1986). *Class and Health: Research and Longitudinal Data*. London: Tavistock Publications.